CENTERS FO	R MEDICARE & MEDI	CAID SERVICES			OMB NO. 0938-0391		
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED		
		15G460	B. WING	-	09/08/2011		
		<u> </u>		ADDRESS, CITY, STATE, ZIP CODE			
NAME OF	PROVIDER OR SUPPLIE	ER	<b>I</b>	ASH ROAD			
DUNGA	RVIN INDIANA LLC	;		OLA, IN46561			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATI	COMPLETION		
TAG			TAG	DEFICIENCY)	DATE		
W0000							
	This visit was fo	or an extended	W0000				
	recertification a	nd state licensure survey.					
	Dates of Surve	y: September 7 and 8,					
	2011.	y. September 7 and 6,					
		000074					
	Facility number						
	Provider number						
	AIM number: 1	100244830					
	Surveyors: Tim	Shebel, Medical					
	Surveyor III-Te	am Leader					
	The following f	ederal deficiencies also					
	1	idings in accordance with					
	431 IAC 1.1.	8					
	1	impleted 9-29-11 by C. Neary,					
	Program Coordina	-					
W0149	The facility must	develop and implement	İ	İ	İ		
	written policies and procedures that prohibit						
	mistreatment, ne	glect or abuse of the client.		1			
			W0149	Dungarvin has a writien policy in	10/11/2011		
	Based on observ	vation, record review, and		place tihati prohibitis mistireatimer	nti		
	interview, the fa	acility neglected to assure		neglecti or abuse ofi tihe clientis	:		
	a choking risk p	olan was implemented for		(Policy B-2). All stiafi ati tihe home be retirained on policy B2, as well a	I		
	1 of 1 sampled	client (client #1) with a		clienti# 1's choking risk plan,	ىد		
	choking risk pla			including tihe expectiation tihati no	oti		
				fiollowing a person's risk plan could			
	Findings includ	e·		be viewed as neglecti The Program			
	i maniga merad	<b>C.</b>		Directior has been retirained on			
	Tt C 114 1			Policy B-2. The stiafi who were			
	1	cords were reviewed on		responsible fior monitioring clien#:	1		
	9/7/11 at 12:55	P.M The review		during tihe time tihati she was			

indicated client #1 had a choking incident

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

000974

observed tio noti be fiollowing her

(X6) DATE

Any defiency statement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY		
		A. BUI	LDING	00	COMPLE	ETED	
		15G460	- 1	B. WING 09/08/2011			)11
NAME OF F	AD OUTDED ON GUIDNI TEN		_	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER			55693 A	ASH ROAD		
DUNGAF	RVIN INDIANA LLC			OSCEC	DLA, IN46561		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	TΕ	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		ad a previous choking			choking plan procedures have		
	incident on 9/3/0	9. A follow up report of			received additional disciplinary		
	the 4/14/11 incid	ent which was dated			action and retiraining		
	5/10/11 indicated	l client #1 was to have			The Program Coordinatior will revi		
	her food "choppe	ed up in to dime size			all incidenti reportis and ensure til all risk plans are being fiollowed	ııatı	
		er indicated "all staff			Systiem wide all Program		
	have been trained				Directior/QMRP's will review tihis		
	nave occii tranice	a Oir billio.			stiandard and assure tihati tihis		
	Client #1 was ab	sourced on 0/7/11 during			concern is being addressed ati all		
		served on 9/7/11 during			Dungarvin ICF-MR's.		
	U 1	observation period from			Persons Responsible: Program		
		:47 P.M At 6:00 P.M.,			Coordinator, Program Director		
		anola bar which was not			/QMRP		
		nto dime size pieces. At					
	6:35 P.M., client	#1 ate her evening meal					
	which consisted	of mashed tater tots,					
	whole kernel cor	n and fish sticks cut into					
	5/8 inch by 1 1/2	inch sections. Direct					
	_	next to client #1 as the					
	client ate her eve	ning meal. Direct care					
		ssist or prompt client #1					
		r food into dime size					
	_	1 100d into diffic size					
	pieces.						
	Client #1's record	ds were reviewed on					
		M A review of the					
		ndicated a 4/16/11					
		The plan indicated					
	direct care staff were to "Use a food						
	-	d (client #1's) food.					
	Grind/chop food	to be no larger than a					
	dime size pieces	{added 5/2/2011} (added					
	to client #1's 4/16	6/11 choking risk plan on					
	5/2/11.)	- 1					
	Ź						

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/13/2011 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION ID		II 15G460			NSTRUCTION  00	(X3) DATE SU COMPLE	
				DING	<del></del>	09/08/2011	
			B. WING		DDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER			55693 A	SH ROAD		
DUNGAR	RVIN INDIANA LLC			OSCEO	LA, IN46561		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	COMPLETION DATE
		erviewed on 9/8/11 at		1110			Ditte
		e #1 stated direct care					
		ground or chopped					
		a bar and fish sticks into					
		me size or smaller."					
	•						
	The facility's reco	ords were further					
	reviewed on 9/9/	11 at 1:50 P.M A					
	review of the fac	ility's "Policy And					
		rning Individual Abuse,					
	-	ploitation" dated 4/11					
		, "Neglect or abuse of					
	•	ient) is strictly prohibited					
	• • • • • • • • • • • • • • • • • • • •	ervice delivery location.					
		shall be free from					
	neglect."						
	1.1-3-2(a)						
W0249		erdisciplinary team has					
	formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed						
		services in sufficient					
	•	ency to support the eobjectives identified in the					
	individual program						
		•	W(	)249	All stiafi working ati tihe sitie will b	e	10/11/2011
	Based on observa	ation, record review, and			retirained on Client#1, #2, and #3's	s	
	interview, the fac	cility failed to assure			IPP's, including tihe medication		
	-	tives were implemented			administiration goals fior tihose people. Ati leasti montihly		
		d clients (clients #1, #2,			observations will be conductied by	,	
	and #3.)				tihe Program Directior or designee	tio	
					assure tihati each stiafi is		
	Findings include	•			implementing tihese goals during medication passing times. This wil	, [	
					medication passing times. This wil		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: G4GR11 Facility ID:

000974

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY COMPLETED		
AND PLAN	OF CORRECTION	15G460	A. BUI	LDING	00	09/08/2011	
		130400	B. WIN			09/00/2011	
NAME OF F	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE		
DUNGAE	RVIN INDIANA LLC			1	ASH ROAD DLA, IN46561		
					7L71, 114-0001		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES  CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION	
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	DATE	
		nd #3 were observed			be documentied on an Active		
		ations from direct care			Treatimenti Observation fiormA co	рру	
	"	ne 9/8/11 observation			ofi tihose fiorms will be given tio t		
		A.M. until 8:45 A.M			Program Coordinatior fior review a	and	
	_	ient #1 was administered			fiollow up		
	· ·	lications. During the			Systiem wide, all Program		
		irect care staff #5 was			Direction QMRP's will review tihis stiandard and assure tihati tihis		
	· ·	prompt or assist client #1			concern is being addressed ati all		
	·	etoprolol medication			Dungarvin ICF-MR's.		
	· ·	art medication) or state			Persons Responsible: Program		
	,	At 8:27 A.M., client #2			Coordinator, Program Director		
	was administered				/QMRP		
		•					
		ring the medication					
	l '	irect care staff #5 was					
	_	prompt or assist client #2					
		osages of her Geodon and					
		on (mood stablizing					
	·	t 7:23 A.M., client #3					
	was administered	<del>-</del>					
		ring the medication					
	· ·	irect care staff #5 was					
	·	prompt or assist client #3					
	1	took Allopurinol					
	medications (gou	it medication.)					
	G1:	1 0/0/11					
		d was reviewed on 9/8/11					
		review of the client's					
	8/12/10 Individua	_					
		ent had the following					
		nistration objective:					
	l ' ' ' '	Metoprolol and state why					
	she takes it."						

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			STRUCTION 00	(X3) DATE SURVEY COMPLETED	
		15G460	A. BUILDING B. WING 09/08/2011				
NAME OF PROVIDER OR SUPPLIER  DUNGARVIN INDIANA LLC			55	5693 AS	DDRESS, CITY, STATE, ZIP CODE SH ROAD .A, IN46561		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Client #2's record was reviewed on 9/8/11 at 10:26 A.M A review of the client's 4/26/11 Individual Program Plan indicated the client had the following medication administration objective: "Learn dosage of Geodon and Prozac medication."  Client #3's record was reviewed on 9/8/11 at 11:07 A.M A review of the client's 4/19/11 Individual Program Plan indicated the client had the following medication administration objective: "State why he takes Allopurinol {for gout}."  Program Director #1 was interviewed on 9/8/11 at 11:56 A.M Program Director #1 indicated all medication administration objectives should have been implemented during the 9/8/11 morning medication administration. 1.1-3-4(a)		IE PRE	FIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	(X5) COMPLETION DATE
W0263	programs are condinformed consent of client is a minor) of Based on record facility failed to a prior to impleme behavior program	review and interview, the secure written consent	W026	3	The Program Direction/QMRP will be retirained on assuring tihati Behave Intiervention Plans tihati include restirictions are noti implementied witihouti tihe writien infiormed consenti ofi tihe person's guardian Quartierly Program Direction/QMRI	ior	10/11/2011

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15G460		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 09/08/2011			
NAME OF PROVIDER OR SUPPLIER  DUNGARVIN INDIANA LLC			STREET ADDRESS, CITY, STATE, ZIP CODE  55693 ASH ROAD  OSCEOLA, IN46561				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PERCEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(X5) COMPLETION DATE			
	programs.  Findings include  Client #3's record 9/8/11 at 11:07 A indicated client # a guardian to pro Review of the cli Intervention Plan receiving Zoloft medication) for coreview of the clie Intervention Plan facility received from client #3's g plan's implement  Program Director 9/8/11 at 11:56 A #1 indicated the written evidence consented to the	ds were reviewed on a.M The review displayed the services of vide informed consent. The review displayed the client was continued to client was continued to consent depression. Further ent's 5/11 Behavior displayed to indicate the written informed consent depression.  The reviewed displayed to the displayed to the displayed to the displayed to the displayed to the displayed to the displayed to the displayed to the plan prior to the plan displayed to the plan displayed to the services of the plan displayed to the plan dis		will conducti auditis ofi tihe clientifiles. This auditi will include assur tihati approvals by a person's guardian are made based on identified need fior any restiriction. These auditis will be reviewed by Program Coordinatior fior fiollow assurance.  Systiem wide all Program. Direction/QMRP's will review this stiandard and tihe need tio assure tihati tihis concern is being address ati all Dungarvin ICFMR's.  Persons Responsible: Program. Director/QMRP, Program. Coordinator.	ing ns tihe up		
W0369	assure that all drug	ug administration must gs, including those that are are administered without					
	interview, the fac	ation, record review, and cility failed to assure 2 of es of medications were	W0369	The stiafi person responsible fior t medication error has been retirair on tihe specific concerns notied in survey reporti All stiafi ati tihe ho	tihe		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: G4GR11 Facility ID:

000974

If continuation sheet

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li ´		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED
15G460		B. WIN			09/08/2011	
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE	
DUNGAE	N //N   IN   D   A N   A			1	ASH ROAD	
DUNGAR	RVIN INDIANA LLC			USCEC	DLA, IN46561	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)		TAG	•	DATE
		ording to physician's			has reviewed tihis stiandard as we The Program Directior, fiacility nur	
		clients observed taking			and designee's will conducti rando	·
	medications (clie	ent #5.)			medication passing observations a	
					tihe home witih various stiafi tio	
	Findings include:	:			ensure consistiency in tihe	
	Diment and 4 CC	//2			medication passing systiem	
	Direct care staff				All ICF Program Directiors will revie	
	_	edications to client #5			tihis stiandard and assure tihati tih issue is being evaluatied as a possi	
	•	1 observation period			concern in all ICF-MR's.	JIE
		intil 6:47 P.M. At 5:13			Persons Responsible: Program	
	· · · · · · · · · · · · · · · · · · ·	staff #2 administered a			Director /QMRP, Facility Nurse	
	_	blet of Vitamin C and a				
	•	blet of Ferrous Sulfate				
	*	dication) to client #5.				
	•	vation period, client #5				
	was not observed	I to eat food until 6:41				
	P.M. during the e	evening meal.				
		al record was reviewed				
		30 A.M A review on				
		1 Physician's Orders				
		owing: "Vitamin C 500				
		ablet, Give 1 tablet orally				
	2 times a day wit	h meals. Ferrous Sulfate				
	325 mg tablet, G	ive 1 tablet orally 2 times				
	a day with meals	."				
	Nurse #1 was into	erviewed on 9/8/11 at				
	1:22 P.M Nurse	e #1 indicated direct care				
	staff should have	administered client #5's				
	Vitamin C and Fe	errous Sulfate tablets				
	with food.					
	1.1-3-6(a)					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE C	(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A DIJII DING	00	COMPLETED	
	15G460		A. BUILDING 09/08/2011		
			B. WING	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF I	PROVIDER OR SUPPLIER		ı	ASH ROAD	
DUNGA	RVIN INDIANA LLC		I	OLA, IN46561	
DUNGA			OSCE	OLA, 11146361	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX		CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
W0382	Based on observate facility failed to a remained locked of 8 clients living #1, #2, #3, #4, #5  Findings include  Clients #1, #2, #3, were observed at the 9/8/11 observate. A.M. until 8:45 Addirect care staff # for client #2. Dit the medication in care staff #5 place medication on a retrieve client #2 unsecured. Direct to the area at 8:27 Addirect care staff #5 prepared #3. Direct care staff #5 prepared #3. Direct care staff #5 prepared #3. Direct care staff	except when being nistration.  ation and interview, the assure all medication until administration for 8 g in the facility (clients 5, #6, #7, and #8.)  3, #4, #5, #6, #7, and #8  the group home during ration period from 6:17  A.M At 8:23 A.M., #5 prepared medications rect care staff #5 placed into a small cup. Direct red the cup with the table and left the area to g, leaving the medication of the care staff #5 returned reconds later but then left a.M. to retrieve client #2. #5 returned to the area 20 to 8:39 A.M., direct care medications for client staff #5 placed the a small cup. Direct care	W0382	All direct care staff at the site be retrained on the medicati passing guidelines, which incensuring that all drugs and biologicals are locked except during times of preparation for administration. Retraining we completed with the staff obset to not follow this practice. Observations during med-patimes will be completed by the Program Director/ QMRP, far nurse, or other designee. Immediate feedback is given during these observations for concerns noted. Medication errors including concerns of violations to the standard of ensuring all drugs and biologare to be locked except during times of preparation for administration will be handle through retraining and discip action according the Dungar policy and procedure on Medication Administration. System wide, all Program Director/QMRPs and nurses review this standard and assist that this concern is being addressed at all Dungarvin ICF-MR's.Persons  Responsible: Program Director/ QMRP, Facility Nurse in the standard in the standard in the standard in the standard in the standard in the standard and assist that this concern is being addressed at all Dungarvin ICF-MR's.Persons	ton clude  t or ill be erved ssing ne cility  r any  d linary vin  will sure

000974

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY  COMPLETED	
15G460		A. BUILDING 09/08/2011					
		100100	B. WIN		ADDRESS, CITY, STATE, ZIP CODE	00/00/20	,,,
NAME OF P	PROVIDER OR SUPPLIER				ASH ROAD		
DUNGAF	RVIN INDIANA LLC				DLA, IN46561		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	COMPLETION
TAG	medication on a tretrieve client #3 unsecured. Directo the area 15 secured. Nurse #1 was into 1:22 P.M Nurse #2, #3, #4, #5, #6 access to the mediance. Nurse #1	erviewed on 9/8/11 at e #1 indicated clients #1, 5, #7, and #8 had free dication area of the group further indicated all ald remain locked until	TAG		DEFICIENCY)		DATE
W0455	prevention, control infection and common based on observation facility failed to a clients preparing #4, #5, and #6) where to handling food.  Findings include:  Clients #1, #2, #4  observed during to period from 3:47  Upon entering the workshop, direct clients #1, #2, #4		W	0455	All directi care stiafi ati tihe sitie w retirained on tihe expectiation tiha clientis wash tiheir hands prior tio handling fiood during times ofi me preparation.  The Program Directior, fiacilitiy nur and designee's will conducti rando observations ati tihe home witih various stiafi tio ensure consistient tihe fiood handling requirementis All ICF Program Directiors will reviet tihis stiandard and assure tihati tih issue is being evaluatied as a possi concern in all ICF-MR's.  Persons Responsible: Program Director /QMRP, Facility Nurse	ati all se m cy in ew is	10/11/2011

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

l	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G460	(X2) MULTIPLE CO  A. BUILDING  B. WING	00	l` ´	E SURVEY PLETED (2011
NAME OF PROVIDER OR SUPPLIER  DUNGARVIN INDIANA LLC			55693 A	ADDRESS, CITY, STATE, ZIP CO ASH ROAD DLA, IN46561	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
	they handled bre and condiments is sandwiches. Clie #6 were not obse upon entering the handling food its sandwiches. Dir observed to pron #2, #4, #5, and # prior to handling  Nurse #1 was int 1:22 P.M. Nurse staff #1 should hassisted clients #	#1 assisted the clients as ad, lunch meats, cheese, in the preparing of their ents #1, #2, #4, #5, and erved to wash their hands a facility or before ems in the preparation of eet care staff #1 was not apt or assist clients #1, 6 in washing their hands food items.  Berviewed on 9/8/11 at see #1 indicated direct care ave prompted and 1, #2, #4, #5, and #6 in ands prior to handling				